STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G741	A. BUILDING 01 B. WING	09/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	9824 TRENTMAN ROAD FORT WAYNE, IN46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/19/11 Facility Number: 011504 Provider Number: 15G741 AIM Number: 200889050 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, AWS was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies. This one story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors,	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sleeping rooms and common living areas. The facility has a capacity of 4 and had a census of 4 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches of Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.3. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/21/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0130	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview the facility failed to ensure a monthly fire extinguisher inspections was documented, including the date and initials of the person performing the inspections for 2 of 3 portable fire extinguishers. NFPA 101, Section 4.5.7 states any device, equipment, system required for	K0130	K130 Training has been completed with the staff at this home in regard to checking fire extinguishers monthly. The maintenance walk throughs are also completed monthly by the professional staff, which indicates that the extinguishers have been checked and the form is turned into and monitored by the Residential Director. The staff were trained that not only should checks be included on the	10/19/2011

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	compliance with the Code shall thereafter be maintained unless the code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all occupants. Findings include: Based on observations with the Residential Director and the Residential Manager on 09/19/11 from 12:01 p.m. to 12:09 p.m., the inspection tag on the fire extinguisher located in the laundry room and the fire extinguisher in the garage lacked initials of a monthly inspection since March 2011. Based on an interview with the Residential Director and the Residential Manager at the time of observations, no other		Monthly Walk Through, but also on the fire extinguisher tag.	

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	documentation was available for review.			
KS043	No door in any means of escape is locked against egress when the building is occupied. Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5. Based on observation and interview, the facility failed to ensure the method to open 1 of 4 sleeping room doors was obvious. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one that is familiar to the average person. In most occupancies, it is important a single action unlatch the door. This deficient practice affect one of four clients. Findings include: Based on an observation with the Residential Director and the Residential Manager on 09/19/11 at 12:11 p.m., from inside of front sleeping room # 1 with the door closed, the lever type door knob	KS043	K0043- A work order was completed and sent to Byall Homes to have a new door handle installed on the door leading to the front sleeping room #1 prior to the survey. The work had been completed and the new door handle has been installed. All other doors in the home have handles that are functioning properly. AWS has a monthly maintenance walk through that the manager completes that should check for proper closure. The form is then reviewed by the director to ensure compliance.	10/19/2011

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	spun around several time before it caught the latching mechanism and the door could be opened. Based on an interview with the Residential Manager at the time of observation, he was aware of the broken door knob and had put in a service request.			